Supreme Court, U.S.
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No. 99-1383

In The

Supreme Court of the United States

U.S. HEALTHCARE, INC.,

Petitioner,

v.

STEVEN BAUMAN AND MICHELLE BAUMAN,
Individually and as Administrators *ad prosequendum*
of the Estate of Michelina Bauman, deceased,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

This is a state law medical malpractice action. In addition to naming the doctor and hospital as defendants, plaintiffs Steven and Michelle Bauman named a non-traditional defendant – their health maintenance organization (HMO), U.S. Healthcare. Defendant U.S. Healthcare removed this medical malpractice action to federal court claiming that because the Baumans received their health benefits pursuant to an "employee benefit plan" subject to the Employee Retirement Security Act (ERISA), 29 U.S.C. §§1001-1461, their claims against U.S. Healthcare were "completely preempted" under section 502(a) of ERISA, 29 U.S.C. §1132(a). The United States Court of Appeals for the Third Circuit rejected U.S. Healthcare's arguments, finding that none of the Baumans' claims was preempted under Section 502(a), and remanded the case to state court.

The question presented is:

> Does Section 502(a) of ERISA "completely preempt" state law medical malpractice claims against an HMO that are based on the HMO providing or causing others to provide medical treatment that falls below the standard of care simply because the injured party's medical care was provided pursuant to an employee benefit plan subject to ERISA?

Moreover, Petitioner's statement of the Question Presented misstates the facts. Plaintiffs' claims *are* based on actions taken in the course of treatment, e.g., the action of discharging Michelina from the hospital only twenty-four hours after birth and the action of failing to re-admit

QUESTION PRESENTED – Continued

Michelina to the hospital the following day when the parents reported her symptoms. For both actions, plaintiffs assert that U.S. Healthcare's policies were a substantial contributing cause.

PARTIES

The parties to this action are defendant U.S. Healthcare, Inc. (Petitioner) and plaintiffs Steven and Michelle Bauman, individually and on behalf of their deceased daughter, Michelina Bauman (Respondents). The other parties are defendants Kennedy Memorial Hospital and Dr. Kamila Nemeh, who have not participated actively in the proceedings in federal court.

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The opinion of the Third Circuit is reported at 193 F.3d 151. The opinion of the District Court is reported at 1 F. Supp. 2d 420.

JURISDICTION

Petitioner claims "federal question" subject matter jurisdiction under 28 U.S.C. §1331, a contention rejected by the Third Circuit. The Third Circuit rendered its decision on September 16, 1999, and denied U.S. Healthcare's petition for rehearing en banc on November 19, 1999. Petitioner's App. (hereinafter "App.") 42a-43a. Petitioner invokes this Court's appellate jurisdiction pursuant to 28 U.S.C. §1254(1).

STATUTORY PROVISIONS

Section 502(a) of ERISA, 29 U.S.C. §1132(a)(1)(B), provides:

> (a) A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]

STATEMENT OF THE CASE

A. Facts

Michelle Bauman gave birth to her first child, Michelina Bauman, on May 16, 1995, at Kennedy Memorial Hospital in Washington Township, New Jersey. App. 45a. Pursuant to the "twenty-four-hour discharge" policy of Michelle Bauman's U.S. Healthcare HMO,[1] Dr. Kamila Nemeh (Michelina's pediatrician) discharged Michelina Bauman from the hospital the next day, May 17, 1995, approximately twenty-four hours after she was born. Dr. Nemeh failed to diagnose that Michelina was suffering from a Group B strep infection prior to discharge. App. 46a.

Beginning at 6:00 a.m. on the day following discharge, May 18, 1995, Steven and Michelle Bauman telephoned Dr. Nemeh several times to report symptoms indicating Michelina was ill. Dr. Nemeh failed to arrange for the Baumans to have Michelina re-admitted to the hospital. App. 49a. In addition, on May 18, 1995, the Baumans telephoned U.S. Healthcare's L'il Appleseed Program and requested an immediate in-home visit by a pediatric nurse to evaluate Michelina. U.S. Healthcare failed to respond to this request. App. 51a. Michelina Bauman died later in the day on May 18, 1995, at two days old, from meningitis caused by the Group B strep infection that went undiagnosed, and consequently, untreated. App. 46a-47a.

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[1] U.S. Healthcare has identified the Health Maintenance Organization of New Jersey, Inc. ("HMO-NJ") as its subsidiary.

B. Procedural History

The Baumans filed this medical malpractice action in New Jersey Superior Court on May 12, 1997. App. 44a-54a. They alleged malpractice by defendants U.S. Healthcare, Kennedy Memorial Hospital, and Dr. Nemeh. Almost immediately, U.S. Healthcare filed its Notice of Removal to federal court, claiming federal question jurisdiction. U.S. Healthcare contended that plaintiffs' state law medical malpractice claims against it were transformed into claims "to recover benefits due" under Section 502(a) of ERISA simply because the Baumans received their health care benefits through a health care plan subject to ERISA.

In addition to claims against U.S. Healthcare for vicarious liability and for negligent selection and supervision of Dr. Nemeh, plaintiffs' Complaint focused on three separate actions by U.S. Healthcare that either constituted medical malpractice or caused it to occur. The first action was U.S. Healthcare's decision to adopt a twenty-four-hour discharge policy, which, plaintiffs alleged in Counts One and Two, was a substantial factor in causing Michelina Bauman to be discharged from the hospital too soon. The second action was U.S. Healthcare's decision to adopt a policy discouraging hospital admissions, which, plaintiffs alleged in Count Five, was a substantial factor in Dr. Nemeh's decision not to re-admit Michelina to the hospital the next day despite serious symptoms of illness. The third action, alleged in Count Six, was U.S. Healthcare's negligent failure to provide the Baumans with a timely in-home visit from a pediatric nurse.

Plaintiffs moved to remand this action to state court, asserting that all claims against U.S. Healthcare were medical malpractice claims, not claims to "recover benefits due" under section 502(a) of ERISA. The Honorable Stanley S. Brotman, U.S. District Judge, agreed that plaintiffs' claims against U.S. Healthcare for its twenty-four-hour discharge policy and its policies discouraging hospital re-admissions were medical malpractice claims. He concluded "that Counts One, Two and Five of Plaintiffs' Complaint do not fit within the scope of section 502(a)." App. 36a. The district court interpreted Count Six, however, as stating a claim for "failing to provide a benefit due under the plan [which] fits within the scope of Section 502(a)." App. 37a. Since Judge Brotman found this claim completely preempted under section 502(a), it followed that it was preempted under ERISA's express preemption provision, section 514(a), 29 U.S.C. §1144(a). He therefore dismissed Count Six against U.S. Healthcare, but remanded all remaining claims against U.S. Healthcare and the other defendants to New Jersey state court. App. 37a-39a.

On appeal, the Third Circuit held that none of the claims against U.S. Healthcare was completely preempted. It therefore reversed the dismissal of Count Six and ordered remand of the entire case to state court. App. 22a.

In affirming Judge Brotman's holding that Counts One, Two, and Five were not completely preempted under Section 502, the Third Circuit relied on several factors. First, the court examined the specific language of Section 502 referring to an "action . . . to recover benefits due . . . under the terms of the plan," and noted that "the

Baumans do not claim anywhere in these counts that they were denied any of the benefits that were due under the plan." App. 17a. Second, the court reiterated the distinction drawn in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995), between claims directed to the *quality* of care provided, which are not completely preempted, and claims that a plan participant did not receive a *quantity* of benefits due under the terms of his plan. The court observed that the applicable counts of the Baumans' Complaint "are phrased in terms of the quality of medical care provided." 18a. Finally, the Third Circuit emphasized the distinction between claims against an HMO acting in its role as administrator of health benefits, which are preempted, and claims against an HMO acting in its role as provider or arranger of medical services, which are not. The court concluded that these counts did not address "plan administration decisions, but rather decisions that the HMO allegedly made in the course of arranging for the provision of medical services." App. 19a.

In reversing the district court's finding that Count Six was completely preempted, the Third Circuit declared: "the mere fact that the Baumans referred in their complaint to a benefit promised by their health care plan does not automatically convert their state law negligence claim into a claim for benefits under section 502." App. 21a. Instead, the court determined that Count Six was not preempted based on another important distinction: this count was premised on U.S. Healthcare's failure to meet the standard of care under state tort law, rather than a violation of a contractual promise made to the Baumans in their ERISA plan. App. 20a-21a.

ARGUMENT

I. THE DECISION BELOW IS CONSISTENT WITH DECISIONS BY OTHER COURTS OF APPEALS.

Contrary to the statements in the Petition for Certiorari, Pet. 7, the Baumans' Complaint **does** allege that the medical care provided to their baby Michelina while she was at Kennedy Memorial Hospital was inadequate, and **does** allege that the medical diagnosis and treatment was improper. The Baumans allege that U.S. Healthcare's twenty-four-hour discharge policy caused Michelina, who was suffering from a Group B strep infection, to receive care that was medically inadequate on May 17, 1995, namely the care necessary to promptly diagnose and treat this infection. In addition, the Baumans allege that U.S. Healthcare's policy regarding hospital admissions caused Michelina to receive medically inadequate care on May 18, 1995, namely the care necessary to promptly diagnose and treat this infection through rehospitalization. Finally, the Baumans allege that U.S. Healthcare's negligence in failing to provide a timely in-home visit by a pediatric nurse caused Michelina to receive medically inadequate care, namely the care necessary to enable another medical professional to diagnose this infection and arrange for immediate treatment.

On the other hand, unlike every case from other courts of appeals that Petitioner cites as supporting its argument, the Baumans do **not** allege that they requested medical treatment that was denied by their health care plan. Regarding Count One, the Third Circuit stated:

> This is not a claim that a certain benefit was requested and denied. . . . U.S. Healthcare's

> policy and incentive structure were such that "the Baumans never had the option of making an informed decision as to whether to pay for the hospitalization themselves," as would occur in a situation in which coverage is sought and denied.

In re U.S. Healthcare, Inc., 193 F.3d 151, 163 (3d Cir. 1999).

Regarding Counts One, Two, and Five, the Third Circuit further concluded that "none of these counts . . . alleges a failure to provide or authorize benefits under the plan, and the Baumans do not claim anywhere in these counts that they were denied any of the benefits that were due under the plan." *Id.* at 162. In addition, even though Count Six referred to a benefit (an in-home pediatric nurse visit) promised by U.S. Healthcare, it was not a benefit that U.S. Healthcare denied or for which it refused to authorize payment pursuant to its role as benefits administrator, but rather a service that it negligently failed to promptly arrange for in its role as medical provider. *Id.* at 164.

In this case, the absence of a denied request for benefits by an HMO, acting in its role as benefits administrator, stands in stark contrast to every case from other circuits that the Petitioner claims are conflicting. Each of the cases cited by Petitioner involves a specific request to the HMO, acting as benefits administrator, for a benefit under the plan and a specific denial of that request for benefits by the HMO as not covered by the plan.

For example, Petitioner cites *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999), as primary support for its argument that the case below conflicts with decisions by numerous other courts of appeals. Pet.

8. Yet, *Danca* involved a request for specific benefits and a denial of that coverage under an ERISA plan. Pamela Danca, who had a long history of mental illness, sought care for a new episode of mental illness in September 1994. Her physician requested treatment at a specific psychiatric hospital (McLean) where she had been successfully treated in the past. Pursuant to a utilization review process, defendants "*denied* precertification for treatment at McLean and instead precertified Danca's admission to Emerson Hospital." 185 F.3d at 3 (emphasis added). Later, allegedly as a result of inadequate care at Emerson Hospital, Danca attempted suicide by self-immolation and sustained horrific injuries. On the basis of this denial of specific benefits pursuant to utilization review, the First Circuit concluded Danca's claims were properly characterized as an "alternative enforcement mechanism" to a Section 502(a) action to recover benefits due. *Id.* at 5. No such denial of specific benefits pursuant to a utilization review process or anything similar occurred in the claims asserted by the Baumans in the case below.

"Utilization review" or "pre-certification review" is a process whereby plan participants must obtain advance approval for certain medical procedures or hospitalizations. When a patient's physician recommends a particular treatment, the HMO or its designee performs an independent review to determine whether the plan will authorize (i.e., pay for) the physician's recommended treatment. *See Dukes*, 57 F.3d at 359; *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331-32 (5th Cir.), cert. denied, 506 U.S. 1033 (1992).

Petitioner now refers to its twenty-four-hour discharge policy as an "administrative pre-certification review policy" in a blatant attempt to characterize the instant case as one, like *Danca*, involving utilization or pre-certification review. This characterization must fail, however, because there are fundamental differences between Petitioner's twenty-four-hour discharge policy and actual pre-certification review. Pre-certification review is a *process* involving an administrative determination; in contrast, twenty-four-hour discharge was a *policy* that impacted upon providers' medical decision-making. As the Third Circuit observed, U.S. Healthcare policies "adversely influenced the medical judgment of its participating providers." 193 F.3d at 163. In pre-certification review, the administrator's benefits decision is controlling; in contrast, under twenty-four-hour discharge, the medical provider's decision was discretionary. As the Third Circuit noted, "U.S. Healthcare's statement at oral argument that the twenty-four hour pre-certification policy is not a hard and fast rule and can be extended as the doctor sees fit only reinforces the view that it is a discretionary medical decision rather than an administrative one." *Id.* at 164.

For these reasons, Petitioner's reliance on *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000), to support its argument alleging a conflict within the circuit courts is similarly unavailing. *Thompson*, unlike the decision below, involved a request for specific benefits that was denied by the entity administering the patient's health care benefits. Mrs. Thompson suffered from breast

cancer, and her treating physicians requested authorization from Gencare for high-dose chemotherapy accompanied by an autologous bone marrow transplant. "Gencare *declined* to pre-certify this treatment." 202 F.3d at 1073 (emphasis added). Because this claim involved a benefits administrator denying authorization for payment for a requested benefit not covered under the plan, the Eighth Circuit held it was completely preempted under Section 502. This result does not conflict in any way with the decision below which does not involve any claims that were denied as not covered by the plan.

Petitioner also claims that *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999), conflicts with the decision below. Yet, *Hull* also involved a request for a specific benefit (a thallium stress test) by the plaintiff's primary care physician that was denied by the plan administrator. "Dr. Fallon, the Plan's administrator . . . *denied both requests* for a thallium stress test and instead authorized a treadmill stress test." 188 F.3d at 941 (emphasis added). The Eighth Circuit concluded that because Dr. Fallon "denied the thallium tests as part of a determination of benefits owed by the Plan[,]" the plaintiff's claims were preempted by Section 502(a) of ERISA. *Id.* at 943.

All of the other cases finding complete preemption under Section 502 of ERISA (or conflict preemption under Section 514 of ERISA) cited by Petitioner, Pet. 10-11, show the same pattern of a specific treatment that was requested by a patient or her physician, followed by a specific denial of this benefit by a person making a determination of benefits under the plan. *See Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) (Jass requested physical therapy for her knee after knee

replacement surgery, which the HMO's utilization review administrator denied as not medically necessary); *Cannon v. Group Health Serv., Inc.*, 77 F.3d 1270 (10th Cir.), cert. denied, 519 U.S. 816 (1996) (Cannon's physician requested authorization for an autologous bone marrow transplant to treat her leukemia but it was denied by her HMO pursuant to a specific provision in her plan); *Parrino v. FHP, Inc.*, 146 F.3d 699 (9th Cir.), cert. denied, 525 U.S. 1001 (1998) (Parrino's physicians, after removal of a brain tumor, prescribed proton beam therapy to reduce the chance of recurrence, but the HMO administering Parrino's health plan initially refused to authorize payment for the therapy claiming it was experimental and unnecessary); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (Tolton requested in-patient psychiatric care for his suicidal tendencies, but this care was not authorized by the entity providing mental health benefits to plan participants); *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir. 1993), cert. denied, 510 U.S. 1045 (1994) (Kuhl's physicians requested authorization for specialized heart bypass surgery at a hospital in St. Louis, but a utilization review coordinator refused to pre-certify payment for the surgery because the hospital was outside the service area covered by the plan); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), cert. denied, 506 U.S. 1033 (1992) (Corcoran's physician sought approval for hospitalization because of high risk pregnancy, but utilization review entity denied authorization based on its determination that hospitalization was not necessary).

The decision below conflicts with none of the above cases cited by Petitioner because, unlike all of those cases,

the Baumans' claims do **not** involve a request for treatment followed by a denial of benefits requested under their plan. Moreover, the decision below is consistent with cases from a number of other courts of appeals that find no ERISA preemption in situations where there is no request for and denial of benefits. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995) (claims against HMOs for vicarious liability of plan physicians and for negligent selection and supervision of those physicians not preempted under section 502 of ERISA because they involve quality, not quantity, of benefits, and do not involve utilization review); *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269 (2d Cir. 1994) (claim against health care entity for negligent hiring and supervision of psychotherapist is not a suit "to recover benefits due" under Section 502 of ERISA); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (claim that HMO is vicariously liable for malpractice of physician provider not properly recharacterized as claim within Section 502 of ERISA); *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332 (5th Cir. 1999) (claims against HMO for vicarious liability and negligent selection of physician who failed to diagnose heart defect not completely preempted under section 502 of ERISA); *Pacificare of Okla. v. Burrage*, 59 F.3d 151 (10th Cir. 1995) (claim that HMO vicariously liable for medical malpractice of primary care physician not preempted under Section 514 of ERISA).

II. THIS COURT'S REVIEW IS UNNECESSARY BECAUSE THE DECISION BELOW ADDS CLARITY, NOT CONFUSION, TO THIS AREA OF THE LAW.

The above discussion demonstrates that there is actually a remarkable amount of consistency among the various courts of appeals that have considered whether state law medical malpractice claims are completely preempted by, and therefore properly re-characterized as claims under, Section 502 of ERISA. In those cases in which a plaintiff's claim is based on failure to provide medical treatment that was requested but denied pursuant to a benefits determination under an ERISA plan, the courts of appeals have found preemption under section 502 of ERISA. In all other cases, the circuit courts have found no preemption under Section 502. The decision below falls within this latter category.

While Respondents agree with Petitioner that this issue is important because "ERISA affects virtually all Americans who obtain health benefits through a private employer," Pet. 13, Respondents do not agree that complete preemption under ERISA "will continue to perplex and divide the federal courts until this Court steps in." Pet. 16. Rather, the courts of appeals have developed an evolving jurisprudence on this issue with much consensus. The decision below represents an important doctrinal step forward in this evolving jurisprudence that will further clarify this issue in the lower courts.[2]

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[2] For a number of reasons, the quotes from the periodical articles cited by Petitioner are not convincing evidence that there is general confusion on Section 502 complete preemption.

What is important about the case below is that it elucidates two tests courts can apply to determine whether a particular medical malpractice claim is completely preempted by Section 502. The first helpful test provided by the court is based on understanding the dual role of the HMO in today's managed care environment: "the same HMO may have assumed both the role as a plan administrator and the separate role as a provider of medical services." *In re U.S. Healthcare,* 193 F.3d at 162. Using this test, the Court was able to categorize the Baumans' claim based on U.S. Healthcare's twenty-four-hour discharge policy as directed at "the HMO's role in 'arranging for medical treatment' rather than its role as a plan administrator determining what benefits are appropriate." *Id.* Similarly, Count Six of the Baumans' Complaint is not preempted under Section 502 because it is "directed toward the HMO's action in its capacity as a medical provider, rather than as a benefits administrator." *Id.* at 164.

Even more important than the distinction the decision below draws between the HMO acting as plan

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First, three of the articles are from 1996, when the law in this area was just beginning to evolve. Second, the credentials of the authors are unknown and it is not uncommon for authors to justify their articles by referring to confusion in the law. Third, the articles apparently refer to all federal cases, rather than to courts of appeals cases which are important here. Finally, the quotes refer to ERISA preemption generally, making no distinction between complete preemption under Section 502 and conflict preemption under Section 514; this indicates that either the authors of these articles are confused themselves about this area of law or that the confusion they refer to may relate to Section 514, which is not at issue in this case.

administrator and the HMO acting as medical provider or arranger is the distinction drawn between actions based on the standard of care and those based on rights created by the ERISA plan. The court held that Count Six was not completely preempted under Section 502 because it presented "a cause of action for violating a tort duty 'to provide [the Bauman family] adequate medical care, rather than a violation of a [contractual] promise . . . made to them in their ERISA plan.' " *Id.* The court further opined that if U.S. Healthcare "failed to meet the *standard of care* required of healthcare providers by failing to arrange for a pediatric nurse in a timely manner, Count Six sets forth an ordinary state-law tort claim for medical malpractice." *Id.* (emphasis added).

This focus on whether plaintiffs' claims for alleged medical malpractice are based on requirements under the standard of care (as opposed to requirements under the ERISA plan) is present throughout the Third Circuit's decision. For example, the court analyzes U.S. Healthcare policies encouraging twenty-four-hour discharge and discouraging the re-admission of newborns as conflicting with what the "appropriate standard of care required otherwise under state law." *Id.* at 163. This focus is crucial because it analyzes the true nature of plaintiffs' claims as alleged in their Complaint. It therefore adds additional clarity to the inquiry under Section 502 preemption analysis as to whether plaintiffs' claim should be "properly re-characterized" as a claim under Section 502 of ERISA. Since the decision below is not only consistent with, but also provides additional clarity to, existing law in this area, there is no need for this court to intervene.

CONCLUSION

For all of the reasons stated above, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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